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Surgical Treatment of Uterine Fibroids.

AND

A REPORT OF TWELVE SUCCESSFUL CASES.

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Throughout the field of gynæcology there is no subject calling forth so much interest, at the present time, as uterine fibroids.

No branch of gynæcology is receiving so much attention, and in none are more radical changes taking place, not only in the interpretation of the importance of fibromata, but also in the method of treatment. Their etiology is still an unsolved problem, all authorities agreeing that, in spite of the mass of theories presented, no definite conclusions have as yet been reached. To the careful worker, large opportunities are here presented for original investigation.

Clinically, the views concerning them have undergone marked changes within the last few years. No longer are fibroids regarded as innocent growths, "benign tumors" of but little import, to be left to the efforts of kind nature to cure when and how she may. A fuller understanding has come of their possibilities, as regards the health and life of the

patient, and, coincident with this, better methods of operative treatment.

The time was not far distant when, owing to the fearful mortality, the abdominal surgeon refused to operate upon uterine fibroids; and when, owing to a mistake in diagnosis, he found, upon opening the abdomen, that the tumor was fibroid instead of ovarian, in dismay, he quickly closed the abdomen, lamenting his unfortunate mistake.

By transitional epochs, amid fierce discussions have been evolved operative measures for their relief until the present time, shows a technique so perfect that a uterine fibroid can be removed with as little risk to the patient's life as an ovarian cyst.

The scope of this paper will include,

First. The presentation to the general practitioner of the best and latest views regarding the clinical history of uterine fibroids and the indications for operative treatment; and

Second. The surgical treatment, with report of cases.

The gynæcological surgeon is as dependent upon the hearty and intelligent co-operation of the general practitioner for the successful issue of his fibroid operations, as he is for his operations for cancer. Physicians have learned to send their cases of epithelioma and carcinoma *early* for operative treatment before the patients have become exsanguinated by hæmorrhages and septic by absorption of foul discharges, with the resulting better statistics and longevity for the patient. And when physicians will likewise send cases of fibroids *early* for surgical measures, before the patients have become nervous wrecks from hæmorrhage and pain, then will the results be alike creditable to the specialist and the general practitioner.

Clinically the relative frequency of fibroids is interesting.

In looking over my gynæological records from January, 1894, to May, 1895, I find that out of two hundred and twenty cases treated at my clinic, seven suffered from fibroids, or a little over three per cent.—out of two hundred and sixty cases treated in private practice, nineteen were fibroids, or a little over seven per cent., and out of a total of four hundred and eighty cases treated, twenty-six were fibroids, or five and four one-hundredths per cent. Thus is shown a marked disproportion in the frequency of fibroid growths in the social condition of the patients, those in the better walks of life showing more than double the number. All of the twenty-six patients came for treatment for the relief of symptoms of greater or less severity induced by the presence of fibroids.

The size of the tumor varied from that of a goose egg to that producing visible abdominal enlargement, and reaching various points at or below the umbilicus. Of the twenty-six cases, the youngest was twenty-six years and the oldest ninety-two years. Two were between the ages of twenty and thirty years, ten were between thirty-five and forty, nine between forty and fifty, and five were past fifty years. Thus the greatest frequency was shown to be between thirty-five and fifty years—nineteen out of the twenty-six being between these ages. Of the five past the menopause, no evidence could be gained that any of the growths had decreased since the cessation of menstruation. In three of them, on the contrary, repeated examinations and the symptoms of the patients showed increased size.

The oldest patient, whose age was 92, presents rather a remarkable history. I was called to see her for the relief of complete prolapsus of the vagina. Upon examining, to determine the cause, found a large fibroid filling the pelvis and extending 10 c. m. above the pubes. Owing to the relaxed

and flabby condition of the senile tissues, the fibroid could be clearly mapped out. It was free from adhesions and gave rise to but few symptoms, except the prolapsus and bladder irritation. She gave a well-authenticated history of having had an ovarian, or "fluid tumor," of the right side, diagnosed over fifty years previously. Repeated consultations were held, and finally she was prepared for operation; but her courage failing her at the last moment, she refused to be operated upon. There was a spontaneous disappearance about the menopause, and freedom from pelvic manifestations until the present time, a period of over forty years. This is the oldest recorded case of uterine fibroids that I have been able to find.

As to the number of children borne by each patient, out of twenty-six, nine were sterile, eleven had one or two children born in early married life, then a long period of sterility followed by evidence of tumor, and six had three or more children. The majority of the cases showed either total or long continued sterility, demonstrating the greater frequency of fibroids in sterile women, and the perversion of normal functional activity into pathological channels.

As to symptoms, all the patients had pressure symptoms, backache, bearing down or reflex pains through pelvis and abdomen, except one, in whom the growth was centrally located and without adhesions. These symptoms varied from a sense of discomfort to actual inability to walk, or perform the ordinary duties of life. All the patients who had not reached the menopause with the exception of six, had hemorrhages either in the form of menorrhagia or metrorrhagia.

As a result of pathological study and clinical observation, certain deductions can be accurately formulated.

1. That fibromata are, as a rule, *growing* tumors—usually of slow growth.

2. During their process of evolution, attacks of local peritonitis are frequent, producing adhesions binding them to the bladder, the rectum, the omentum and the intestines.

3. Their presence almost without exception produces weight and bearing down sensations with various reflex disturbances in the back and abdomen, increasing in severity with growth of the tumor and the proximity of the neoplasm to important structures.

4. Hemorrhages, either metrorrhagia or menorrhagia sap the vitality of nearly four-fifths of the patients having fibromata.

5. That they are likely at any time in their growth to undergo degenerative changes, particularly after the menopause when the patient's vitality is weakened and resistant power is lowest. Besides the usual degenerative processes that take place within the tumor, there may be infection with the result of pus formation in either the uterus or appendages or sloughing, or degeneration into carcinoma.

6. As a result of compression upon neighboring organs or obstruction in circulation, structural changes take place in vital and distant organs notably in the urinary system, producing sometimes a fatal pylonephritis or in the cardiac muscle resulting in fatty degeneration or brown atrophy.

In the face of this evidence, what course shall be pursued in the treatment of fibroids? There is no evading the accumulated evidence that the tendencies in the course of a fibroid are toward grave complications and disaster. Every fibroid should be so regarded and treated accordingly. If the tumor is small, giving rise to no symptoms and not growing,the patient should be placed under the best possible conditions and kept constantly under observation. In all other cases, early and active measures should be instituted at once. Before taking

up the treatment, one word about the necessity of care in diagnosis of fibroids. Though in many cases it is comparatively easy to make the diagnosis of fibromata, it is always well to bear in mind that growths diagnosed as fibroids may be of still more serious character. They may be solid growths of the ovary, cancer of the ovary or uterus, or pyo-salpinx with induration of the pelvic roof. At times, it is most difficult to differentiate pus tubes with adhesions from a mass of small uterine fibroids, projecting through the pelvis and bound down by adhesions. In both are found nodulated masses distributed through the pelvis. Only careful bimanual examination and close investigation into the history of the patient will make clear the diagnosis.

I consider *surgical* measures the only ones to be considered in the treatment of these neoplasms. Medical treatment has not given results sufficient to warrant our waiting for the slow and uncertain action of medicine in these serious growths.

As for the electrical treatment, the patients, as a rule, have come to the surgeon after being treated with electricity in a worse condition than if they had not had the treatment; the danger of septic infection is greater and the adhesion are denser than they otherwise would have been.

INDICATIONS FOR OPERATION.

The indications for operation are—a growing tumor even if it is only moderate in size; hemorrhages either at the menstrual period or irregularly; pain and pressure symptoms and the presence of pyo-salpinx.

The size of the tumor plays but little part in the decision as to its removal, a small tumor often producing more serious symptoms than one of larger growth. It depends upon its position in the pelvis and its proximity to the endometrium.

The dangers of the operation increase in direct proportion to the size of the tumor, the age of the patient and the reduction of vitality by repeated hemorrhage.

The fatal cases are usually the neglected ones or cases come for care that are no longer operable, in which simple and satisfactory results could have been obtained a few years previously. One such case came under observation during the past year. Five years before coming for consultation, the patient had had uterine fibroid diagnosed; it was small and gave comparatively little discomfort. She was advised to have nothing done; after five years of neglect I found her condition most deplorable, the tumor had not only grown upward into the abdominal cavity but downward into the pelvis, accurately adapting and insinuating itself into the curves of the pelvis. It was impossible to lift the growth or pass the finger at any point between it and the bony wall of the pelvis. How the bladder and bowels performed their functions was a marvel. She was an anæmic, nervous wreck from long-continued pain and hemorrhages, and when told that an operation at this stage would be a formidable one, she had neither the moral courage nor physical strength to meet it. An operation when the tumor was first discovered would have been a simple procedure, the years of suffering avoided, and her life prolonged.

OPERATION.

Under improved technique and early operation, it is interesting to watch the reduction in the mortality of fibroid operations.

Burnham and Kimball's statistics in the early fifties show a mortality of eighty per cent. This was gradually reduced from sixty to thirty-five per cent, where it stood about ten years ago at the beginning of the era of advances in abdomi-

nal surgery, since then it has gone on progressing until now it is almost nil.

As to the methods of operation, no plan can be chosen for all cases alike, each one must be carefully individualized and the method most appropriate chosen for it. There are six well-indorsed methods before the profession for the operative treatment for uterine fibromata.

1. Removal of uterine appendages. (Hegar, Tait).

2. Tying of uterine arteries through the vagina. (Franklin Martin).

3. Cœlio Myomectomy, removing the tumor leaving the uterus intact. (Martin of Berlin).

4. Removal of sub mucous fibroids through the Os Uteri and Vagina.

5. Supra vaginal hysterectomy.

(*a*) Intra-peritoneal stump (Sehroder, Goffe).

(*b*) Extra-peritoneal stump. (Krobaeh, Eastman, etc).

6. Total Extirpation.

(*a*) Cœlio-hysterectomy. (Polk, Krug, etc.).

(*b*) Vaginal Hystereetomy, Moreellement. (Péan, Ségond, Doyen).

(*c*) Cœlio-calpo hysterectomy or combined operation; separation of cervix from vagina by vaginal route and removal of tumor through abdominal incision.

1. The removal of uterine appendages as originated by Tait and Hegar for the control of uterine fibroids was originated upon the theory that fibroids ceased to grow after the menopause. It was hoped that by inaugurating an artificial menopause to bring about an atrophy of the neoplasm, but it is abundantly proven that the menopause does not modify the growth of these tumors, hence the operation does not fulfill the

required indications, and it will be but a short time before it is relegated to things of the past.

2. The tying of the uterine arteries may occasionally be of value when we have a bleeding uterus and for some reason, either through weakness of the patient or organic lesions, it is impossible to perform a radical operation. This method may offer some hope of relief, it must always be regarded, however, in the light of a palliative measure.

3. Myomectomy as originated and developed by Martin, of Berlin, in 1878, though limited in its sphere of work still has its clear cut and most important indications. In conservative measures, when in young women, it is desirable to maintain a functionating uterus and appendages and with otherwise normal conditions, there exist one or two sub peritoneal fibroids this is the method to be pursued. When operation is indicated for fibromata in women under thirty-five years, a careful bimanual examination should always be made to determine if myomectomy instead of hysterectomy can not be performed.

INDICATIONS FOR MYOMECTOMY.

(a) When the uterus possesses only pedunculated tumors.

(b) In tumors having a well developed fibrous capsule and which are neither so large nor numerous nor so placed as to require in removing, such direct damage to uterus or its blood supply as will unfit the organ for proper functional activity.

If carefully performed and the uterine incision closely united by buried layers of fine catgut with a Hagedorn needle, there is no more danger of hemorrhage in myomectomy than in hysterectomy.

4. For sub mucous and interstitial fibroids that have become sub mucous, removal through the cervix and vagina is the only method to be employed.

5. Though a few cases of fibroids may be treated by myomectomy or by removal through the cervix, the great majority of cases requires the removal of the uterus or a *hysterectomy.* Among American surgeons in the last few years, supra vaginal hysterectomy with either the extra peritoneal treatment of the stump or the intra peritoneal treatment has been and is still with many a favorite operation. The endless discussions concerning the treatment of the cervix show that neither method is perfect. It is no more surgical to leave a stump to slough in the lower angle of the abdominal wound, with in time an almost invariable ventral hernia, any more than it is surgical to run the risk of septic infection through the cervical canal in the intra peritoneal method.

6. A better, cleaner and more surgical procedure is the total extirpation of the entire organ. Polk and Krug demonstrated what perfect results could be obtained by the abdominal method. The French surgeons by their brilliant statistics have demonstrated the utility and superiority of the vaginal route.

It is in my opinion the method of the future in dealing with uterine fibroids. As we become accustomed to vaginal methods, there will be but few fibroids that we cannot attack by the vaginal route, and as we are perfected in the technique it is amazing the ease and rapidity with which we can work, the readiness with which we can bring down pelvic tissues, separate adhesions, remove appendages with but little loss of blood and scarcely appreciable shock to the patient.

In case the tumor is very large or fixed high in the pelvic, the combined method is to be chosen; it is the work of but a few moments to rapidly separate the cervix from the vagina, enter the anterior and posterior peritoneal cul-de-sacs, then make the abdominal incision and work from above downward. By making the vaginal opening first, we do away with

that which by the abdominal method alone is the most difficult part, *i. e.*, the work deep in the pelvic cavity, and we run less risk of wounding the rectum posteriorily, and the bladder and ureters anteriorily.

From January, 1894, to the present time, I have operated upon twelve cases of uterine fibroids, all with successful results. In every case I have aimed to perform the operation by the vaginal method alone if possible. In looking over the accompanying table, seven were performed by the vaginal route by morcellement, four by the abdomino-vaginal method, and one through the cervix. Of the seven cases performed by morcellement, complications of adhesions or diseased appendages were encountered in varying degrees in each case. The four cases by the abdomino-vaginal method were begun by the vaginal route, but completed by the aid of the abdominal method. In looking back over these cases, complicated though they were, yet were similar cases to be presented in the future, I should make still greater efforts to manage them entirely by the vaginal method alone.

In one case, No. V in the table, the difficulty in the character of the growth which was of the intra-ligamentous variety involving both the broad ligaments transversely, making it impossible to draw the tumor down for the necessary morcellement, and equally difficult to tie off the broad ligaments when working from above. It was a very tedious and complicated case. In case No. VII the difficulty was owing to the size of the tumor which reached almost to the umbilicus, and the number of adhesions. In case No. IX complications were many and troublesome, the patient, a working-woman, was almost bed-ridden from repeated attacks of pelvo-peritonitis and long continued metrorrhagia. Besides a fixed retroverted fibromatous uterus, there was an ovarian cyst reaching mid-

way to the umbilicus. After removing the uterus and fibroids by morcellement, I endeavored to remove the ovarian growth by the vagina, but the tumor was fixed so high in the pelvis that it was neeessary to make an abdominal ineision, separate the adhesions, evaeuate the cyst and ligate from above while the clamps remained in situ on the broad ligaments. In Case No. XI, the obstruction to the downward depression of the uterus was a large sessile sub-peritoneal fibroid situated on the anterior wall of the uterus; its longest axis was transverse, so placed that it could not be drawn below the pubes. After the vaginal separation was completed, I enueleated the tumor through an abdominal ineision, then resumed the morcellement by the vaginal way; the uterus with a mass of small fibroids being quickly drawn down, clamps applied and the operation brought rapidly to a close.

Case No. XII was rather unique. It consisted of a number of small fibroids in the posterior wall of the uterus and one large polypoid fibroma of the body of the uterus, projecting from the cervix and filling the vagina to the vulva. Its longitudinal circumferenee was 24 c. m. and transverse 18 c. m. After removing the vaginal portion of the growth, which enucleating the smaller interstitial growths through the very patulous cervix by the proeess of évidement I aeeidently entered the peritoneal cavity and quite a smart hæmorrhage took place. I immediately everted the body of the uterus through the cervix, made an ineision into the anterior cul-de-sae above the cervix to correspond to the opening posteriorily, drew the broad ligaments well into view and clamped them. I removed the body of uterus through the cervical canal leaving only the vaginal portion of the cervix. Drainage was maintained through the widely opened cervix until cicatrization took place. The patient made an uninterrupted recovery.

OPERATIVE TECHNIQUE OF MORCELLEMENT.

In performing morcellement, I have taken what I consider the best features from Péan's, Ségond's and Doyen's methods, modifying the technique to meet the emergencies of the individual case. I prefer the circular incision at the cervico-vaginal junction, though Ségond's theoretically may afford more protection to the ureters; he makes two additional cuts after completing the circular incision parallel to the lower border of the broad ligaments, thereby hoping to gain more room. I have operated by the circular incision twenty-five times and have never injured a ureter. I am careful to keep very close to the uterus, my incisions as well as blunt dissection being towards the axis of the uterus. The distance of the circular incision from the external os will vary in different cases, dependent upon the size and shape of the cervix. Care must be exercised that it is not made too high for fear of injuring the bladder, nor so low upon the cervix as to miss the "line of cleavage" between the uterus and the bladder, thereby greatly prolonging the operation. I prefer to enter the anterior cul-de-sac first and afterwards the posterior. My next step is the hemi-section of the anterior wall of the uterus and, by grasping section after section of the anterior wall with forceps gradually draw the uterus downward and evert it anteriorily until it is outside the vulva. In most cases of fibroids, morcellement is necessary before this can be accomplished. I prefer not to apply the clamps to the broad ligaments until the morcellement is completed and the uterus outside the vulva, the downward traction being enough to control the hemorrhage, if the broad ligaments or the peritoneum adjacent to them are not accidently cut, making morcellement practically a bloodless operation.

When the uterus is retroverted or the tumor mass more

accessible through the posterior wall, it is then advisable to perform a hemi-section of the posterior wall instead of the anterior. I have found the posterior hemi-section also advisable where the fibroid mass arises from the anterior wall or fundus of the uterus and rests against the pubes so that it is impossible by traction upon the cervix to draw it down. Then firm traction upon the two lateral halves of the posterior wall of the uterus as high as the fundus will succeed in dislodging it and bringing it into the field of operation for the necessary morcellement. It was this method that aided me materially in overcoming the difficulties in the case of fibromata complicated by ovarian tumor, case IX in the table.

I always clamp the broad ligaments from above downward, holding the ligament between the thumb and fore finger of one hand, that no intestines be caught in the bite of the forceps, and slipping the forceps down over the ligament with the other. I usually employ two clamps for each broad ligament, to be sure that the uterine and ovarian arteries are securely caught. I have used clamps in all the cases but two, and these were by the abdomino-vaginal method, in which the ligaments were tied from above with catgut. Clamps are desirable at the time of operation, inasmuch as they are quickly applied, lessening the time of operation, and when properly placed, afford absolute protection from hemorrhage. In after treatment, however, the sloughing incident to their use is unsurgical and unclean. In the evolution of the operation of morcellement, clamps will be given up for a better method. Ligatures do not fully meet the indications for the reason that the ligaments are stretched, many times almost to the vulva for the necessary clamping and ligating, and upon receding after being tied the ligature is very apt to slip.

In six cases the appendages were removed with the uterus,

and in six they were allowed to remain. In those patients where the appendages were removed as well as the uterus, the after results were much better. Their convalescence was characterized by an absolute absence of all pelvic symptoms and was remarkable for its ease and rapidity. As the result of observing patients after their operations, whenever possible, I shall in future remove the tubes and ovaries when it is necessary to remove the uterus, thereby leaving no diseased append ages, with the possibility of future trouble.

No better argument can be offered in favor of any method of operation than the results achieved by that method.

Dr. Howard Kelley, in the bulletin of the John Hopkins Hospital, for October, 1894, gives a report of seventy hysteromyomectomies, performed by the combined intra and extra peritoneal method. The death rate was 4.2 per cent. Owing to the skill of the operator, and the ideal conditions surrounding him, this can be taken as a type of the best American work.

By morcellement, the statistics of ten of the best French operators show seven deaths out of 406 cases, a mortality of 1.7 per cent., a result that has never been approached by any other method.

My motive in presenting this report of cases for the consideration of the profession is to call the attention to the success of this method as yet but little practiced in America, but which I am certain is destined to rank as one of our most successful and brilliant operations.

I wish to extend to Dr. J. W. Ward my thanks for his courtesies extended during the operations and in the after-care. I wish also to thank Dr. Susan J. Fenton and Dr. Cadwell for their untiring care for such of the patients as were operated upon at Fabiola Hospital.

SURGICAL TREATMENT OF UTERINE FIBROIDS.

NO.	NAME—AGE.	Social Condition.	DATE.	CLINICAL HISTORY.	DIAGNOSIS.	OPERATION.	CONVALESCENCE.	RESULT.
1	Miss M. S. Æt. 38.	Single.	Mar. 11,1894	Menstruation every 3 weeks, persisting four-teen days, progressive weakness and emaciation, unable to pursue occupation of teaching.	Interstitial and subperitoneal fibroids of the uterus.	Vaginal method. Uterus removed by morcellement. Ovaries and tubes removed; clamps used	Clamps removed in thirty-four hours: recovery uneventful. Pulse 76–80; temp. once 101°. Diarrhœa complicated recovery.	Recovery
2	Mrs. S. G. Æt. 43.	III para.	May 18, 1894	Constant pain in abdomen, back and thighs: inability to work. Bedridden.	Sub-peritoneal fibroid; large hard hyperplastic uterus, fixed by adhesions. Enlarged and prolapsed left ovary.	Vaginal method. Uterus euretted and os closed with catgut. Both ovaries removed: clamps. Large hermatoma of left ovary.	Clamps removed in thirty-six hours: recovery uneventful. Pulse 90–100; temperature once 102–2; discharged in three weeks.	Recovery
3	Mrs J. A. H.	II para.	Apr. 22, 1894	Inability to walk or stand, owing to pain in left side and back.	Sub-peritoneal fibroid, and large adherent ovaries; uterus fixed by adhesions.	Vaginal method. Adhesions posteriorly rendered operation difficult. Doyen's clamps. Morcellement.	Clamps removed in thirty-six hours; fourth day after operation on attempting to move bowels recto-vaginal fistula established. Gradual closure.	Recovery
4	Mrs. A. J. Æt. 48.	II para.	Oct. 7, 1894	Severe sacral Backache, constant aching through pelvis, increased through menstruation: menorrhagia.	Multiple interstitial and subperitoneal fibroids of the uterus.	Vaginal method. Clamps. Tubes and ovaries not removed. Morcellement.	Uninterrupted, temperature normal throughout convalescence.	Recovery
5	Mrs. J. S. Æt. 41.	I para.	Dec. 30,1894	Pressure symptoms, pain in both ovarian regions, worse on left side, making walking painful and difficult. Menstruation normal.	Multiple-subperitoneal and interstitial fibroids of the uterus,	Vagino abdominal method. Morcellement found impossible due to great size of tumor and its extension into both broad ligaments, rendering it impossible to draw uterus down to work upon it; vaginal attachments severed first followed by ecceliotomy; long and tedious due to adhesions and shortened broad ligaments. Through gauze drainage. Ovaries and tubes removed.	Good except for mural abscess in abdominal walls.	Recovery
6	Mrs. A. E. W. Æt. 50.	I para.	May 2, 1894	Bedridden for 3 years. Multitude of nervous manifestations, under constant medical attention for 5 years.	Multiple subperitoneal and interstitial fibroids.	Exploratory incision revealed tumor so imbedded in pelvis that Vaginal Hysterectomy chosen. Morcellement. Doyen's clamps.	Clamps removed in thirty-six hours. Recovery uneventful.	Recovery
7	Mrs. P. Æt. 45.	I para.	Oct. 11, 1894	Abdominal enlargement noticed one year ago, increasing in size with constant "spotting," discharge for last two years; increasing menorrhagia pressure symptoms in pelvis and back.	Multiple subperitoneal and interstitial fibroids weighing 12½ lbs.	Vagino-abdominal method. Owing to size of tumor impossible to bring the mass low enough in pelvis to perform morcellement. Vaginal attachments and peritoneum severed centrally and posteriorily, through vagina. Then removal through abdominal incision. Removal of tubes and ovaries. Through gauze drainage. Catgut ligatures on both broad ligaments.	Gauze drainage removed in forty eight hours. Uninterrupted recovery.	Recovery
8	Mrs. A. F. H. Æt. 53.	III para.	Mar. 5, 1895	Constant backache and inability to walk; pelvic tenesmus on least exertion; excessive menorrhagia. Bedridden 15 days in every month.	Interstitial fibroids.	Doyne's clamps. Uterus, tubes and ovaries removed.	Clamps removed in thirty-six hours; recovery uneventful; temperature once 101°; pulse 125; Convalescence otherwise normal.	Recovery
9	Mrs. G. Æt. 37.	II para.	Mar. 7, 1895	Constant flow for about one year. Pain in both ovarian regions, soreness and weight in pelvis, incapacitating her for work.	Multiple-fibromata. Ovarian cyst of right side; pelvic peritonitis, with diffuse adhesions through pelvis.	Morcellement of fibromatous uterus by vaginal method, followed by removal of ovarian tumor through abdominal incision. Doyan's clamps used in broad ligaments. Left ovary and tube being normal were not removed.	Uninterrupted recovery; temperature never rose to 100. Abdominal wound healed by first intention; clamps removed in 36 hours.	Recovery
10	Miss. H. Æt. 35.	Single.	Mar. 12,1895	More or less constant flow for four months, constant pain, soreness and tenderness in pelvis, backache.	Multiple subperitoneal and interstitial fibromata.	Morcellement. Vaginal method leaving both tubes and ovaries.	Uninterrupted, uneventful convalescence; patient out of bed in two weeks	Recovery
11	Mrs. H. C. Æt. 49.	Nulliparа.	Mar. 3, 1895	Profuse bi-monthly menstruation, noticable abdominal enlargement with pains in region of tumor.	Sub-peritoneal and interstitial fibroids.	Cervico-vaginal incision with separation of vaginal tissues, impossible to draw down uterus, enucleation of large fibroid, through abdominal incision; removal of uterus and small fibroids through vagina. Doyen's clamps; ovaries and tubes not removed.	Uneventful; clamps removed in thirty-six hours; union of abdominal incision first intention; patient out of bed in two weeks.	Recovery
12	Mrs. E. B. Æt. 43.	III para.	Mar. 17,1895	Regular menstruation until 5 years previously, but suffered greatly with spasms of pelvic pain, worse through menstruation. Since that time constant painless hemorrhages. Dull dragging through back, worse in lumbar regions.	Polypoid fibroma of body of uterus, projecting from uterus, and filling vagina. Small fibroids of posterior wall of uterus.	Enucleation of vaginal tumor and amputation of body of uterus, through cervix. Doyne's clamps on broad ligament through cervix.	Clamps removed in thirty-six hours; drainage by gauze into cervix, swabbing followed by douching on 6th day; uninterrupted convalescense.	Recovery